



COMMONWEALTH OF MASSACHUSETTS
EXECUTIVE OFFICE OF HEALTH AND HUMAN
SERVICES DEPARTMENT OF PUBLIC HEALTH
BUREAU OF HEALTH PROFESSIONS LICENSURE
BOARD OF REGISTRATION OF PHYSICIAN

ASSISTANTS

250 Washington Street
BOSTON, MA 02108
800-414-0168
617-973-0806

www.mass.gov/dph/boards/pa

**TEMPORARY PRACTICE CERTIFICATE APPLICATION
INSTRUCTIONS AND CHECKLIST**

Please read these instructions carefully. All supporting materials must be submitted at the same time. Applications will not be reviewed by the Board until all documentation has been received.

General Information About the Application Process:

The Board of Registration of Physician Assistants ("Board") highly recommends that you refrain from accepting a PA position in Massachusetts until you are licensed.

Once an application is received by the Board, it takes a **minimum of 3 - 5 weeks** to review the completed application and determine if any additional information is required. Once complete, applications are processed for the issuance of a license in the order received. Every effort is made to process license applications in a timely manner; however, the Board is unable to expedite the processing of applications.

To facilitate the processing of your application, please ensure that you provide all the information requested. **DO NOT LEAVE BLANKS.** If you are unable to provide the requested information, attach a separate sheet with an explanation. Missing information will delay the processing of your application.

As an applicant, it is your responsibility to ensure that ALL supporting documentation for licensure is sent directly to the Board and to check with the Board on the status of your application.

All requested information must be provided; failure to provide requested information may result in a delay in processing an application. **Incomplete applications will be returned to applicant.**

Complete applications must include the following documents:

- ☐ Completed application form, signed and dated by the applicant and notarized.
- ☐ 2x2 passport style color photo; white or off-white background; copies and printer generated photos are not acceptable.
- ☐ Signed and notarized Criminal Offender Record Information (CORI) Acknowledgement Form obtained from the Board's website.
- ☐ Check or money order payable to the Commonwealth of Massachusetts for \$150.00; cash or foreign currency is not accepted.
- ☐ Official transcripts in signed, sealed envelopes from physician assistant programs/degrees with

proof of a bachelor's degree or higher. When requesting official transcripts, please inform each school's

the transcript must be complete and indicate the degree and date conferred in mm/dd/yyyy format.

☐ NCCPA documentation that states you are registered for, and have been determined to be eligible to take, the next available administration of the physician assistant certification examination administered by NCCPA.

NOTE: The documentation must be sent directly from NCCPA; email verifications are not acceptable.

☐ Verification of licensure status, in signed, sealed envelopes, from any state or jurisdiction in which you now have or have ever held any professional license or board certification. Verifications must be sent directly to the Board by the state or other jurisdiction.

For Massachusetts licenses only, the Board also accepts printed, self-queries of online verification of licensure from the following: the Board of Registration in Dentistry, the Board of Registration in Nursing, the Board of Registration in Pharmacy, the Board of Certification of Community Health Workers, the Board of Registration of Genetic Counselors, the Board of Registration in Naturopathy, the Board of Registration of Nursing Home Administrators, the Board of Registration of Perfusionists, the Board of Respiratory Care, the Nurses Aid Registry, and the Office of Emergency Medical Services for EMT, Advanced EMT and Paramedic Certification. Any printed, self-queries of online verification of licensure must be submitted with the application packet.

☐ Submission of a completed application and fee acknowledges that the applicant understands and agrees to all provisions herein. Applications are void if requirements for physician assistant licensure are not met within one (1) year from the date of Board receipt of this application. All fees are non-refundable and non-transferable.

☐ Completed MassHealth Attestation form.

☐ Application must be submitted on single-sided paper.

☐ Retain a copy of the completed application and related documentation for your records. **The Board is not able to provide copies of the application.** Employers may require that you provide them with a copy.

*A Supervising Physician form with a MA Board of Registration in Medicine Physician Profile and Work Setting Information form must be on file with the Board within thirty (30) days of beginning employment. Physician Profiles are available online at www.massmedboard.org. Your license may be issued without these forms.

NOTE A: If there has been no change in supervising physician[s] and/or work setting[s] since a Temporary Practice Certificate was issued, new forms do not need to be resubmitted.

NOTE B: Multiple supervising physicians and work settings require submission of separate forms for each supervising physician and each work setting.

IMPORTANT INFORMATION:

Pursuant to 263 CMR 3.03 (4) this cite is incorrect, Board regulations state that a physician assistant applicant/registrant must notify the Board in writing of any of the following events within thirty (30) days of their occurrence: change of address of applicant/registrant; change of identity of the applicant/registrant's employer or employment status of the applicant/registrant; any change in the identity or address of the registered physician supervising the practice of the applicant/registrant; or, the permanent departure of the applicant/registrant from the Commonwealth of Massachusetts.

Your address is a PUBLIC RECORD that is available to anyone who requests it. If you are using your home address, you may wish to consider changing this to an office address. Address changes may be done online at the board's website www.mass.gov/dph/boards/pa or you may obtain a form online to submit to the Board's office.

Answers to many questions may be found on the Board's website. Statutes and regulations governing physician assistant licensure and practice may be found on the website; they are also available for purchase from the State House Bookstore, Massachusetts State House, Room 116, Boston, MA 02108, 617-727-2834.

For further information, please contact the Board office at 1-800-414-0168 or 1-617-973-0806.



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COMPLETE ALL QUESTIONS
TEMPORARY PRACTICE CERTIFICATE FEE -
\$155.00

1. Applicant Name : _____
Last First Middle

a. Maiden Name/Other Name (if applicable):

_____ Last First Middle

2. Address of Record: _____
No. Street
Apt. #

_____ City/Town State Zip Code

3. Most Recent Previous Address: _____
(Different then Address of Record) No. Street Apt. #

_____ City/Town State Zip
Code

4. TELEPHONE NUMBER(S) Day: _____ Evening: _____ Cell: _____

5. _____/_____/_____

Date of Birth (mm/dd/yyyy)

Place of Birth (city/state/country)

HEIGHT: _____Feet_____Inches **WEIGHT:** _____Lbs. **EYE COLOR:** _____

Sex: M F (Circle One) **MOTHER'S MAIDEN NAME:** _____

Email: _____

6. **SOCIAL SECURITY NUMBER (SSN) (disclosure is mandatory):** _____/_____/_____

Pursuant to G.L. c. 62C, s. 47A, the Bureau of Health Professions Licensure is required to obtain your SSN and forward it to the Massachusetts Department of Revenue. The Department of Revenue will use your SSN to ascertain whether or not you are in compliance with Massachusetts tax laws (G.L. c. 62C, s. 47A) and child support laws (G.L. c. 119A, s.16).

FOR BOARD USE ONLY

Application Number: _____

Receipt Number: _____

Temporary Practice Number: PAT _____

Date Issued: _____

EDUCATION

7. I certify under the pains and penalty of perjury, that I have taken or I will register for and take the next available administration of the NCCPA certifying examination

Scheduled date of NCCPA Certification Exam: / /
(mm/dd/yyyy)

Signature: _____ Date: _____

Applicant must arrange for official written documentation of certification to be sent directly to the Board by NCCPA. Request form included with application forms.

8. PA Program Name/Location: _____

Degree awarded: _____ Date of Graduation: / /
(mm/dd/yyyy)

Submit official transcript in a signed, sealed envelope. Transcripts may be mailed directly to the Board.

VERIFICATION OF OTHER LICENSES/BOARD CERTIFICATIONS

9. LIST BELOW ALL OTHER PROFESSIONAL LICENSES AND BOARD CERTIFICATIONS EVER HELD; INCLUDE ALL STATES AND JURISDICTIONS OR check the box below

☐ I DO NOT CURRENTLY HOLD AND HAVE NEVER HELD ANY PROFESSIONAL LICENSE OR CERTIFICATION IN ANY STATE OR JURISDICTION.

<u>Issuing State/Jurisdiction</u>	<u>Profession</u>	<u>License/Certification Number</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Applicants must arrange for official documentation of current license status from each state or jurisdiction to be mailed directly to the Board in a signed, sealed envelope.

For Massachusetts licenses only, the Board also accepts printed, self-queries of online verification of licensure from the following: the Board of Registration in Dentistry, the Board of Registration in Nursing, the Board of Registration in Pharmacy, the Board of Certification of Community Health Workers, the Board of Registration of Genetic Counselors, the Board of Registration in Naturopathy, the Board of Registration of Nursing Home Administrators, the Board of Registration of Perfusionists, the Board of Respiratory Care, Nurses Aid Registry and the Office of Emergency Medical Services for EMT, Advanced EMT and Paramedic Certification.

Any printed, self-queries of online verification of licensure must be submitted with the application

QUESTIONS

IF YOU ANSWER "YES" TO ANY OF THE FOLLOWING QUESTIONS PLEASE ATTACH A SEPARATE SHEET EXPLAINING THE CIRCUMSTANCES.

An applicant for employment or for housing or an occupational or professional license with a sealed record on file with the commissioner of probation may answer 'no record' with respect to an inquiry herein relative to prior arrests, criminal court appearances or convictions. An applicant for employment or for housing or an occupational or professional license with a sealed record on file with the commissioner of probation may answer 'no record' to an inquiry herein relative to prior arrests or criminal court appearances. In addition, any applicant for employment or for housing or an occupational or professional license may answer 'no record' with respect to any inquiry relative to prior arrests, court appearances and adjudications in all cases of delinquency or as a child in need of services which did not result in a complaint transferred to the superior court for criminal prosecution.

10. Have you ever been denied a license, or ever withdrawn or attempted to withdraw an application, for any professional license in the United States or any country or foreign jurisdiction?

Yes ☐ No ☐

11. Has any licensing or certification board, government authority, hospital or health care facility or professional association located in the United States or any country or foreign jurisdiction taken any disciplinary action against you?

Yes ☐ No ☐

12. Are you the subject of any pending disciplinary action by any licensing or certification board, government authority, hospital or health care facility or professional association located in the United States or any country or foreign jurisdiction?

Yes ☐ No ☐

13. Have you ever voluntarily surrendered or resigned any professional license or board certification in the United States or any country or foreign jurisdiction?

Yes ☐ No ☐

14. Have you ever been arrested, charged, arraigned, indicted, prosecuted, convicted or been the subject of any criminal investigation or any court proceeding in relation to any criminal violation? Do not report minor violations for which a fine of \$250 or less was imposed.

Yes ☐ No ☐

15. Have you ever been court martialled or other than honorably discharged from the armed services (military) of the United States or of any country or foreign jurisdiction?

Yes ☐ No ☐

RELEASE

I hereby authorize all hospitals, institutions, credentialing agencies, organizations, personal physicians, employers (past and present), business and professional associates (past and present), and all government agencies and entities (local, state, federal, or foreign) to release to the Board of Registration of Physician Assistants any information, files or records requested by the Board in connection with the processing of my application. I further authorize the Board of Registration of Physician Assistants to release information contained in this application in association with its processing.

AFFIDAVIT OF APPLICANT

To the best of my knowledge and belief, I have filed all state tax returns and paid all state taxes required by state law and do not owe child support.

I understand that the Board is certified by the Massachusetts Department of Criminal Justice Information Services (DCJIS) for access to Criminal Offender Record Information (CORI), including conviction and pending criminal case data.

As an applicant for a temporary practice certificate to practice as a Physician Assistant, I understand that a CORI check may be conducted by the Board for conviction and pending criminal case information only and that the CORI results will not necessarily disqualify me.

I understand that I am responsible for reading and understanding the laws and regulations governing practice with a temporary practice certificate in Massachusetts and I hereby agree to comply with such laws and regulations.

I understand that this application for a temporary practice certificate shall be deemed no longer valid if requirements for a temporary practice certificate are not met within one (1) year from the date of Board receipt. I also understand that fees are non-refundable and non-transferable.

I certify, under the pains and penalties of perjury, that the information I have provided pursuant to this application for licensure is truthful and accurate. I understand that any failure to provide truthful and accurate information in connection with this application for a temporary practice certificate may be grounds for the Board of Registration of Physician Assistants to deny issuance of a temporary practice certificate and to suspend or revoke a temporary practice certificate issued to me, all in accordance with Massachusetts law.

APPLICANT SIGNATURE _____ DATE _____

PRINT NAME _____

**Attach a recent
passport photo
(2x2)**

NOTARY NAME: _____

COMMISSION EXPIRES: _____

[Seal]

ATTESTATION PAGE

Mandatory Registration(s):

The Affordable Care Act¹ requires physician assistants and certain other providers to enroll in MassHealth as a condition of licensure. Specifically, each PA must enroll as a Nonbilling Provider (also known as an Ordering Referral and Prescribing (ORP) provider). Consequently, when applying for initial PA licensure, an individual must first fully complete and submit to MassHealth an application to be a Nonbilling Provider. For more information go to: <https://www.mass.gov/how-to/how-to-enroll-to-be-a-masshealth-orp-provider>

MassHealth will accept your application even though you have not yet received your Massachusetts Physician Assistant license and put it in a “pending” status. If you have submitted the application form to MassHealth, you may attest below that you have “submitted a thoroughly completed nonbilling provider application and signed provider contract to MassHealth” on this application.

After you have obtained your Massachusetts Physician Assistance license, contact MassHealth and MassHealth will change your application status from “pending” to “enrolled.”

☐ I am aware of and have submitted a thoroughly completed application to be a fully participating provider or non-billing provider and a signed provider contract to MassHealth on _____, _____ pursuant to M.G.L. c. 112, s. 9(f)

☐ I consent to the Bureau of Health Professions Licensure and the Massachusetts Executive Office of Health and Human Services, and its enrollment vendor, to obtain, read, copy and share with each other information regarding my MassHealth application and enrollment status and professional licensure status.

<http://www.mass.gov/eohhs/provider/insurance/masshealth/aca/aca-section-6401enrollment-information.html>

☐ I am aware that if I am or become a licensed prescriber, pursuant to M.G.L. c. 94C §24(a), I must utilize MassPAT each time I prescribe a Schedule II-III opioid or benzodiazepines.

☐ Once I have obtained my Physician Assistant License and registered for MassPat, I consent to the Bureau of Health Professions Licensure and the Massachusetts Prescription Monitoring Program to obtain, read, copy and share with each other information regarding my MassPAT enrollment status and professional licensure status

<https://www.mass.gov/service-details/masspat-use-requirements>

Mandatory Training(s):

If you have not completed the one-time courses listed below, you must complete the course to

¹ See also M.G.L.c. 112 § 9F

satisfy initial licensure/ license renewal requirements

☐ I am a prescriber who is aware of the required training and I have completed mandatory training for all **prescribers** in Pain Management pursuant to M.G.L. c. 94C §18(e). I completed the training and received a certificate of completion on: _____, _____. [Note: it is the responsibility of licensees to retain copies of certificates to be provided to the Board upon request at any time].

Course Names: _____

☐ I am aware of and have completed mandatory one-time training on domestic and sexual violence pursuant to M.G.L.c. 112 §264. I completed the training and received a certificate of completion on _____.

Course Name: _____

<https://www.mass.gov/service-details/domestic-and-sexual-violence-integration-initiatives>

☐ I have completed a one-time course of training and education in the diagnosis, treatment and care of patients with cognitive impairments, including, but not limited to, Alzheimer's disease and dementia.

Yes ☐ No ☐

Course Name: _____

There is no prescribed course or number of education hours for this training. If you received any training or education in your academic program, through professional staff development, conferences, seminars or continuing education in the diagnosis, treatment and care of patients with cognitive impairments at any time, then you meet the requirements of the training.

Please note: You may apply for licensure without first meeting this requirement, however all licensees must complete this training and education requirement by November 7, 2022

For your convenience, please see the link below to find CME courses in the diagnosis, treatment and care of patients with cognitive impairments.

☐ I hereby certify that the information herein is true to the best of my knowledge.
Signed under the pains and penalties of perjury:

Print Name: _____

Signature: _____ **Date:** _____



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ASSISTANTS
250 Washington Street
BOSTON, MA 02108
800-414-0168
617-973-0806

www.mass.gov/dph/boards/pa

SUPERVISING PHYSICIAN
FORM FOR
TEMPORARY PRACTICE CERTIFICATE AND
LICENSE APPLICATIONS

Complete this form and submit it to the Board with application for Temporary Practice Certificate or License Application. If you are not employed at the time of application for a Temporary Practice Certificate or a License, return this form to the Board at the above address within thirty (30) days of beginning employment in the Commonwealth of Massachusetts. If you have more than one supervising physician and work setting, you must complete and submit a separate form for each supervising physician and each work setting.

Applicant/PA Name: _____
Last First Middle License/Temp Prac #

Applicant/PA
Address: _____
No. Street City/Town State Zip Code

Date of Employment: _____

Physician Name: _____
Last First Middle License # Specialty

TO BE COMPLETED BY SUPERVISING PHYSICIAN:

I. Have you [the supervising physician] been disciplined [as defined by the Board of Registration in Medicine regulations] by any government authority, hospital or health care facility or professional medical association [international, national or local] within the past ten years from the date of this application?

☐ Yes ☐ No

II. Within the last ten years from the date of this application, have you ever had staff privileges, employment or appointment in a hospital or health care institution denied, suspended or revoked?

☐ Yes ☐ No

III. Within the last ten years from the date of this application, have you ever resigned from a medical staff in lieu of disciplinary action or has any quality assurance committee suggested any form of corrective action concerning your practice?

☐ Yes ☐ No

IV. Within the last ten years from the date of this application, have you ever resigned from a medical staff in lieu of disciplinary action or has any quality assurance committee suggested any form of corrective action concerning your practice?

☐ Yes ☐ No

I understand that, notwithstanding any other provisions of law, a physician assistant may perform medical services when such services are rendered under my supervision. Such supervision shall be in conformance with Board regulations at 263 CMR 5.04 and 5.05.

Signature of Supervising Physician

Date

A MA BOARD OF REGISTRATION IN MEDICINE PHYSICIAN PROFILE MUST BE ATTACHED. PROFILES ARE AVAILABLE ONLINE AT WWW.MASSMEDBOARD.ORG. SEND THE PROFILE AND THE COMPLETED FORM TO THE MA BOARD OF PHYSICIAN ASSISTANTS AT THE ADDRESS ABOVE.



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BOARD OF REGISTRATION OF PHYSICIAN ASSISTANTS
239 CAUSEWAY STREET, SUITE 500
BOSTON, MA 02114
800-414-0168
617-973-0806
www.mass.gov/dph/boards/pa

**WORK SETTING INFORMATION
FOR
TEMPORARY PRACTICE CERTIFICATE AND
LICENSE APPLICATIONS**

Complete a separate copy of this form for each work setting in which you are employed as a physician assistant. If you are not employed at the time of application, return this completed form to the Board of Registration of Physician Assistants, 239 Causeway Street, Suite 500, Boston, MA 02114 within thirty (30) days of commencing employment.

APPLICANT NAME:

(Last) (First) (Middle) (License/Temp. Practice #)

NAME OF FACILITY OR OFFICE: _____

ADDRESS: _____

EFFECTIVE DATE: _____

TYPE FACILITY: Office () Clinic () HMO () Hospital () Other: _____

TYPE EMPLOYMENT: Full time () Part time ()

LIST NAMES OF MASSACHUSETTS'S HEALTH CARE FACILITIES (INCLUDING GROUP PRACTICES) AT WHICH YOU WILL PRACTICE OR BE AFFILIATED WITH IN THIS WORK SETTING:

CHECK ALL AREAS OF PRACTICE THAT APPLY TO THIS SETTING:

<input type="checkbox"/> Primary Care	<input type="checkbox"/> Administration	<input type="checkbox"/> Emergency Medicine
<input type="checkbox"/> General Surgery	<input type="checkbox"/> Internal Medicine	<input type="checkbox"/> Occupational Health
<input type="checkbox"/> Geriatric Medicine	<input type="checkbox"/> Education	<input type="checkbox"/> Clinical Research
<input type="checkbox"/> Obstetrics/Gyn.	<input type="checkbox"/> Pediatrics/Adolescent.	<input type="checkbox"/> Orthopedics
<input type="checkbox"/> Oncology	<input type="checkbox"/> Dermatology	<input type="checkbox"/> Cardiology
<input type="checkbox"/> Medical Specialty _____		
<input type="checkbox"/> Surgical Specialty _____		
<input type="checkbox"/> Other _____		

APPLICATION FOR TEMPORARY PRACTICE CERTIFICATE
BOARD OF REGISTRATION OF PHYSICIAN ASSISTANTS
Revised •02.09.22



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NCCPA CERTIFICATION REQUEST FORM

COMPLETE THIS FORM AND MAIL IT TO:

Retain a copy for your records.

NCCPA
12000 Findley Road, Suite 200
Duluth, GA 30097-1409

I hereby authorize and direct the National Commission on Certification of Physician Assistants, Inc., to release to the

Bureau of Health Profession Licensure
Attention: Massachusetts Board of Registration of Physician Assistants
250 Washington Street
Boston, MA 02108

any and all information concerning my eligibility, examination, and/or certification status, and/or examination scores which the Massachusetts Board of Registration of Physician Assistants may require in conjunction with my application for registration. I hereby release the National Council on Certification of Physician Assistants, Inc., and its agents and employees from any liability arising out of its compliance with such a request for information.

SIGNATURE OF APPLICANT

DATE

1A. APPLICANT NAME: _____
LAST FIRST MIDDLE

1B. PREVIOUS NAME: _____
LAST FIRST MIDDLE

2. ADDRESS: _____
NO. STREET APT. #

CITY/TOWN STATE ZIP

3. DAY TELEPHONE NUMBER: _____ 4. DATE OF BIRTH: ____/____/____
(MM/DD/YYYY)

5. SOCIAL SECURITY NUMBER: ____--____--____

6. DATE OF EXAM: ____/____/____
(MM/DD/YYYY)

APPLICATION FOR TEMPORARY PRACTICE CERTIFICATE
BOARD OF REGISTRATION OF PHYSICIAN ASSISTANTS
Revised • 2-9-2022

MassHealth Enrollment Requirement

Providers listed below must submit this form with your license application/renewals

Section 6401 of the Affordable Care Act requires that, for MassHealth services that must be ordered, referred or prescribed, the provider who ordered, referred or prescribed the service must be enrolled with MassHealth in order for the claim for the service to be payable.

The following provider types are eligible to order, refer or prescribe services for MassHealth members and, under state law, must apply to enroll with MassHealth at least as ordering and referring (nonbilling) providers in order to obtain and maintain state licensure. **Providers who are already enrolled with MassHealth have already met the requirement and do not need to take further action.**

Certified nurse midwife	Pharmacist (if authorized to prescribe)
Certified registered nurse anesthetist	Physician (including interns and residents)
Clinical nurse specialist	Physician assistant
Dentist	Podiatrist
Licensed independent clinical social worker	Psychiatric clinical nurse specialist
Nurse practitioner	Psychologist
Optometrist	

MassHealth has created a Nonbilling Provider Application for providers in provider types that are **not** eligible to enroll as fully participating providers.

Providers who wish to apply to enroll as nonbilling providers must download the materials from the MassHealth website at <http://www.mass.gov/eohhs/provider/insurance/masshealth/aca/aca-section-6401enrollment-information.html> and send their completed and signed Nonbilling Provider Application and Nonbilling Provider Contract by mail to the MassHealth Customer Service Center (CSC) at:

MassHealth Customer Service Center
Attn: Provider Enrollment and Credentialing
PO Box 121205
Boston, MA 02112-1205

Providers who enroll with MassHealth as nonbilling providers via the Nonbilling Provider Application are not fully participating MassHealth providers and are not eligible to submit claims to MassHealth.

Providers who have questions, or, if eligible, would like to request a fully participating provider application should contact the MassHealth Customer Service Center at 1-800-841-2900 with any questions or, if eligible, to request a fully participating provider application.

You must complete this section and sign below in order for your license application/renewal to be processed

___ I am already enrolled with MassHealth as a nonbilling provider

OR

___ I have submitted a thoroughly completed nonbilling provider application and signed provider contract to MassHealth

By signing this form, you are providing your consent for the Massachusetts Boards of Registration and, where relevant, their supervising state agencies and the Massachusetts Executive Office of Health and Human Services, and where relevant, its provider enrollment vendor, to obtain, read, copy, and share with each other information regarding your MassHealth application and enrollment status and Massachusetts licensure status.

I certify under the pains and penalties of perjury that the information on this form has been reviewed and signed by me, and is true, accurate, and complete, to the best of my knowledge. I understand that I may be subject to civil penalties or criminal prosecution for any falsification, omission, or concealment of any material fact contained herein.

By: _____ (Signature)

Name: _____ (Printed Legal Name of Provider)

NPI: _____

Primary Service Location Address: _____

Date: _____